

circumstances will, however, require prospective evaluation in adequately powered randomized studies. New strategies to prevent the development of coronary artery disease in patients with a psychiatric illness such as anxiety or depression may be of special importance in view of the lack of evidence that psychiatric medications such as antidepressant medications decrease cardiovascular risk.⁶

Thus, while the exact mechanisms linking a prior psychiatric hospitalization and a first hospitalization for NCCP to increased cardiovascular and total mortality remain uncertain, we are indebted to Gilles *et al.*⁴ for pointing out the increased cardiovascular risk and the need for cardiovascular evaluation of these patients. The increasing evidence that both vascular disease and psychiatric illnesses such as anxiety and depression share common mechanisms suggests challenges and opportunities for both the psychiatrist and the cardiologist to improve risk detection and to prevent cardiovascular and total mortality in patients with psychiatric illnesses both with and without NCCP. One might consider a strategy such as outlined in *Figure 1* for patients hospitalized with a psychiatric illness such as depression if we are to prevent the development of cardiovascular disease before the patient presents with chest pain and an increased risk of death. This will, however, require a further understanding of the links between psychiatric illness and cardiovascular disease as well as prospective evaluation.

Conflict of interest: none declared.

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CARDIOVASCULAR FLASHLIGHT

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Implantable cardioverter defibrillator avoids shock during electrocution

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A 30-year-old electrician with an implantable cardioverter defibrillator (ICD) who had previous history of idiopathic ventricular fibrillation presented to emergency room after incurring electrocution injury while accidentally grasping a 230 Volt 50 Hz alternating current power line at work. He was in contact with the power line for approximately 3 s though he remained conscious. At presentation, the patient was clinically in stable condition. Physical examination revealed two grade IIa entrance burns of the right palm (*Panel A*, bold arrows) and one grade I exit burn of the left palm (*Panel A*, thin arrow), which served as the ground. The burns were surgically treated by cautious debridement. Subsequently, ICD interrogation revealed appropriate 'noise reversion' (*Panel B*) due to detection of continuous high-frequency sensing in the ventricular channel for 3.3 s avoiding shock delivery. No ventricular tachyarrhythmia was induced during electrocution. However, the heart rate was more rapid after the event, possibly due to sinus tachycardia. All ICD measurements were within the normal range. Twelve-lead surface ECG and the cardiac biomarkers remained normal after the event. The patient was discharged on the same day.

